NORTH ALABAMA FAMILY PSYCHIATRY & COUNSELING

NALFPC Therapist

Adult Initial Assessment / Patient Questionnaire

Patient Name: _____ **Date:** _____

Age: _____ **Date of Birth:** _____/_____/_____

Please read the following questions and answer to the best of your ability by placing a checkmark in the appropriate boxes or filling in the blank as directed. Your cooperation is appreciated.

Referred by: _____

Please describe, in detail, the present problem including when the problem started, how often it occurs and what stressors may contribute to the problem.

_____

_____

_____

_____

_____

_____

_____

_____

Please check ALL of the following symptoms or thoughts that apply to you **AT THIS TIME or during the past six months:**

- □ Depressed mood
- □ Diminished interests or pleasure
- □ Sleep disturbance
- □ Fatigue
- □ Change in appetite
- □ Hopelessness
- □ Pleasure in few activities
- □ Weight change
- □ Agitation
- □ Excessive worry
- □ I feel like I am losing control.
- □ Irritability
- □ Poor Concentration
- □ Tension
- □ Feelings of panic
- □ Socially withdrawn
- □ Use of alcohol
- □ Use of other drugs
- □ Use of tobacco
- □ Anxiety in social settings
- □ Makes careless mistakes
- □ Does not complete tasks
- □ Difficulty organizing
- □ Forgetful
- □ Confusion
- □ Disorientation
- □ Compulsive checking / counting
- □ Indecisiveness
- □ People talk about me.
- □ Some people want to hurt me.
- □ I feel emotionally distant from others.
- □ I hear voices or sounds others do not hear.
- □ I see things others do not see.
- □ I smell things others do not smell.
- □ Racing thoughts
- □ I do risky or dangerous things.
- □ Little interest in sexual activity
- □ Sexual problems
- □ Gender concerns
- □ I don't like my body.
- □ Binge eating
- □ Self induced vomiting
- □ Laxative abuse
- □ Excessive fasting
- □ Intense fear of weight gain
- □ Impulsive
- □ I think about hurting myself.
- □ I have tried to hurt myself.
- □ Sometimes I wish I were dead.
- □ I think about hurting someone else.
- □ Exposed to a significant traumatic event
- □ Recurrent distressing dreams

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Suicide Risk Assessment:

Have you ever had feelings or thoughts that you didn't want to live? □ Yes □ No.
If YES, please answer the following. **If NO**, please skip to the next section.
Do you **currently** feel that you don't want to live? □ Yes □ No
How often do you have these thoughts?_____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____
Do you have access to guns? If yes, please explain. _____
_____

Psychiatric History:

Do you have a prior psychiatric diagnosis? If so, what is it and when did you receive it?
_____
_____
_____
_____

Outpatient treatment □ Yes □ No If yes, Please describe when, by whom, and nature of treatment.

By Whom	Dates Treated	Reason

Psychiatric Hospitalization □ Yes □ No If yes, describe for what reason, when and where.

Where	Dates Hospitalized	Reason

Past Psychiatric Medications: Please list all psychiatric medications you have ever been prescribed.
_____
_____
_____
_____

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Family Psychiatric History: Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	□Yes	□No	Schizophrenia	□ Yes	□ No
Depression	□Yes	□ No	Post-traumatic stress	□ Yes	□ No
ADHD	□Yes	□ No	Learning Disability	□ Yes	□ No
Autism	□ Yes	□ No	Intellectual Disability	□ Yes	□ No
Anxiety	□ Yes	□ No	Alcohol abuse	□ Yes	□ No
Anger	□ Yes	□ No	Other substance abuse	□Yes	□ No
Suicide	□ Yes	□ No	Violence	□ Yes	□ No

If yes, who had each problem?

_____

_____

Has any family member been treated with a psychiatric medication? □ Yes □ No If yes, who was treated, what medications did they take, and how effective was the treatment?

_____

_____

Past Medical History:

Allergies_____Current Weight _____ Height _____

Primary Care Physician_____Phone#_____

Date and place of last physical exam: _____

List ALL current prescription medications and how often you take them: (if none, write none)

_____

_____

_____

_____

Current over-the-counter medications or supplements:

_____

_____

Current medical problems:

_____

_____

Past medical problems, non-psychiatric hospitalization, or surgeries:

_____

_____

Have you ever been treated for a nutritional problem?	□ Yes	□ No
Do you make yourself sick because you feel uncomfortably full?	□ Yes	□ No
Do you worry you have lost control over how much you eat?	□ Yes	□ No
Have you recently lost more than 14 pounds in a 3-month period?	□ Yes	□ No
Do you believe yourself to be fat when others say you are too thin?	□ Yes	□ No
Would you say that food dominates your life?	□ Yes	□ No

Are you experiencing any physical pain? □Yes □ No

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Substance Use:

Have you ever been treated for alcohol or drug use or abuse? □ Yes □ No
If yes, for which substances?_____
If yes, where were you treated and when?_____
How many days per week do you drink any alcohol? _____
What is the least number of drinks you will drink in a day? _____
What is the most number of drinks you will drink in a day? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?_____
Have you ever felt you ought to cut down on your drinking or drug use? □ Yes □ No
Have people annoyed you by criticizing your drinking or drug use? □ Yes □ No
Have you ever felt bad or guilty about your drinking or drug use? □ Yes □ No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? □ Yes □ No
Do you think you may have a problem with alcohol or drug use? □ Yes □ No
Have you used any street drugs in the past 3 months? □ Yes □ No
If yes, which ones? _____
Have you ever abused prescription medication? □ Yes □ No
If yes, which ones and for how long? _____
_____

Check if you have tried any of the following:

□ Methamphetamine
□ Stimulants (pills)
□ Hallucinogens
□ Synthetic drugs
□ Methadone
□ Tranquilizer/sleeping pills
□ Cocaine
□ LSD/ PCP
□ Marijuana
□ Pain Killers (not as a prescription)
□ Alcohol
□ Ecstasy
□ Other _____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:

How you ever smoked cigarettes? □ Yes □ No
Currently? □ Yes □ No
How many packs per day on average? _____ How many years? _____
In the past? □Yes □ No How many years did you smoke? _____ When did you quit? _____
Pipe, cigars, or chewing tobacco: Currently? □ Yes □ No In the past? □ Yes □ No
What kind? _____ How often per day on average? _____ How many years? _____

Family Background and Childhood History:

Were you adopted? □ Yes □ No Where did you grow up? _____
List your siblings and their ages: _____
_____
What was your father's occupation? _____
What was your mother's occupation? _____
Did your parents' divorce? □ Yes □ No If so, how old were you when they divorced? _____

If your parents divorced, who did you live with?_____
Describe your father and your relationship with him: _____
_____
Describe your mother and your relationship with her:_____
_____
How old were you when you left home? _____
Has anyone in your immediate family died? _____
Who and when?_____

Trauma History:
Do you have a history of being abused emotionally, sexually, physically or by neglect? □ Yes □ No.
Please describe when, where and by whom: _____
_____

Educational History:
Highest Grade Completed? _____ Where?_____
Did you attend college? _____ Where? _____Major? _____
What is your highest educational level or degree attained? _____

Occupational History:
Are you currently: □ Working □ Student □ Unemployed □ Disabled □ Retired
How long in present position? _____
What is/was your occupation? _____
Where do you work? _____
Have you ever served in the military? _____ If so, what branch and when? _____
Honorable discharge □ Yes □ No Other type discharge _____

Relationship History and Current Family:
Are you currently: □ Married □ Partnered □ Divorced □ Single □Widowed
How long? _____
If not married, are you currently in a relationship? □ Yes □ No If yes, how long? _____
Are you sexually active? □ Yes □ No
How would you identify your sexual orientation?
□ straight/heterosexual □ lesbian/gay/homosexual □ bisexual □ transsexual
□ unsure/questioning □ asexual □ prefer not to answer □ other_____
What is your spouse or significant other's occupation? _____
Describe your relationship with your spouse or significant other: _____
_____
Have you had any prior marriages? □ Yes □ No. If so, how many? _____
How long? _____
Do you have children? □ Yes □ No If yes, list ages and gender: _____
_____
Describe your relationship with your children: _____
List everyone who currently lives with you: _____
_____

Legal History:
Have you ever been arrested? _____
Do you have any pending legal problems? _____

Spiritual Life:
Do you belong to a particular religion or spiritual group? □ Yes □ No Group: _____
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? □ more helpful □ stressful